Enrollment Form

The Local Choice Health Benefits Program

PART A–ENROLLMENT
PART B–CHANGE MEMBERSHIP AND/OR PLAN
PART C–WAIVE OR CANCEL COVERAGE

Active Employees
- Use this application to enroll if you are a new employee or are changing your membership and/or plan due to a Qualifying Mid-Year Event (life event). For a list of life events, see your Group Benefits Administrator. Submit changes within 31 days of employment or the Qualifying Mid-Year Event. Return the completed application to your Group Benefits Administrator.

Retiring/Retired Employees
- Your application should be completed three months before the date of your retirement. Your Group Benefits Administrator will let you know the method for remitting premium contributions.

Employees/Dependents No Longer Eligible For Health Benefits Coverage
- You must use this enrollment form if you wish to select Extended Coverage (COBRA). The period of time for which you are eligible for Extended Coverage depends on the event which qualified you for this option. You will be responsible for the entire cost of the plan you select plus applicable administrative fees. You must send payments directly to your Group Benefits Administrator.

HEALTH CARE PLANS AVAILABLE

Review the plan information you have received. HMO coverage is offered in Northern Virginia only. Make sure you select a plan that is offered by your employer and available where you live or work.

STATEWIDE SELF FUNDED PLANS:
Administered by:
Anthem Blue Cross and Blue Shield
ValueOptions, Inc.
Delta Dental of Virginia
Medco Health Solutions, Inc. d/b/a Medco

Employee Plans
- Key Advantage with Expanded Benefits
- Key Advantage 200
- Key Advantage 300
- Key Advantage 500
- TLC High Deductible Health Plan

Medicare Eligible Retirees/Dependents
- Advantage 65
- Advantage 65 With Dental/Vision
- Medicare Complementary

REGIONAL FULLY INSURED
HEALTH MAINTENANCE ORGANIZATION (HMO)
Employee Plan
Northern Virginia
(includes Washington, D.C. and parts of Maryland)
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. – HMO

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) SPECIAL ENROLLMENT RULES

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact your Group Benefits Administrator.

PART A. ENROLLMENT

Name _____ Social Security Number _ _
(First Name) (M.I.) (Last Name)

Employee Status
☐ Active ☐ Retired ☐ Extended Coverage

Home Address _____
Mailing Address (if different) _____
_____ Zip _____

Sex: ☐ Male ☐ Female Birth Date: _____ Work Phone: (____) _____ Home Phone: (____) _____
Month Day Year Area Code Area Code

1. I choose the following Health Benefits Plan _____

- If you choose a statewide self-funded plan, you do not need to select a primary care physician.
- If you choose a regional fully-insured plan, with no out-of-network benefits, you agree to the following when you sign this form: I understand that only services provided, directed, or arranged by my selected PCP or Medical Center will be covered, except in an emergency or by prior plan authorization. I understand that all services except emergency services are provided only within the Plan's service area.

2. Current Enrollment:
Applicable to enrollees who are remaining with the same employer but applying for a different plan: If you or any member of your family are now covered by one of The Local Choice Health Benefits Programs, give the name of the plan _____ and the Subscriber's Identification Number _____

3. Dependent Information (must be completed to enroll under Employee Plus One or Family membership)
RELATIONSHIP CODES: **H**=Husband **W**=Wife **S**=Son **D**=Daughter **SS**=Stepson **SD**=Stepdaughter **O**=Other (attach explanation)

Name (Include last name if different)	Birth Date Mo. Day Yr.	Social Security Number	Relationship Code	Regional HMO Only: PCP Number (From Directory Of Providers) Or Name Of PCP If No Number	Regional HMO Only: Check If Currently A Patient Of This PCP
Spouse:					
Children:					

4. Medicare Information (complete if you or enrolled family members are Medicare eligible)

Name of Enrollee _____ Name of Spouse or Dependent _____
Medicare ID Number _____ Medicare ID Number _____
Effective Date: HOSPITAL (PART A) _____ Effective Date: HOSPITAL (PART A) _____
MEDICAL (PART B) _____ MEDICAL (PART B) _____

5. My Type of Membership Will Be:

ACTIVE EMPLOYEE
☐ Single ☐ Employee Plus One (employee and either spouse or child) ☐ Family

RETIREE
☐ Single Retiree Not Eligible for Medicare
☐ Single Retiree Eligible for Medicare
☐ Retiree Eligible for Medicare and Dependents Not Eligible for Medicare
☐ Retiree Not Eligible for Medicare and Dependents Not Eligible for Medicare
☐ Retiree Not Eligible for Medicare and Dependents Eligible for Medicare
☐ Retiree Eligible for Medicare and Dependents Eligible for Medicare

6. Other Coverage (Complete carefully. This information is subject to verification.)
Are you, your spouse, or dependent child(ren) – whether or not they are enrolled under The Local Choice Health Benefits Program – covered by any other group hospital, medical-surgical, dental, or drug program? ☐ Yes ☐ No
If YES, complete the following:

Name of Policyholder _____
Subscriber's Identification No. _____ Employer Group No. _____ Effective Date _____
Month Year

Name of Other Insurance Company _____

Address of Other Insurance Company _____

Name of employer or organization providing the group program _____

Who does the policy cover? (check all that apply) ☐ You ☐ Your spouse ☐ Your children

What does the policy include? (check all that apply) ☐ Hospital and medical-surgical services ☐ Drug ☐ Dental

7. **Certification** – I certify that I have reviewed the information on this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that The Local Choice Health Benefits Program and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Signature _____ Date _____

8. **Premiums** – The current monthly cost to me for the plan and type of membership I have selected is $_____, effective (date)* _____

The current and future cost (if any) of coverage may be deducted from my paycheck. If covered as a retiree, I will make my premium payments directly to my former employer. I understand that in order to terminate coverage, notice of cancellation must be made by completing Part C of the enrollment form and does not relieve me from payment for any month already begun.

Signature _____ Date _____

*Generally, the effective date for coverage is the first day of the month following your Group Benefits Administrator's receipt of this enrollment form. Should you need assistance contact your Group Benefits Administrator.

PART B. CHANGE MEMBERSHIP AND/OR PLAN

Print Name _____ Social Security Number _____ - _____ - _____
(First Name) (M.I.) (Last Name)

I have selected _____ Employer/Department _____
Name of Plan

1. My Type of Membership Will Be:

ACTIVE EMPLOYEE

☐ Single ☐ Employee Plus One (employee and either spouse or child) ☐ Family

RETIREE

☐ Single Retiree Not Eligible for Medicare
☐ Single Retiree Eligible for Medicare
☐ Retiree Eligible for Medicare and Dependents Not Eligible for Medicare
☐ Retiree Not Eligible for Medicare and Dependents Eligible for Medicare
☐ Retiree Eligible for Medicare and Dependents Eligible for Medicare

Medicare Information (complete if you or enrolled family members are Medicare eligible)

Name of Enrollee _____ Name of Spouse or Dependent _____
Medicare ID Number _____ Medicare ID Number _____
Effective Date: HOSPITAL (PART A) _____ Effective Date: HOSPITAL (PART A) _____
MEDICAL (PART B) _____ MEDICAL (PART B) _____

2. Reason This Form Is Being Submitted (check one)

☐ Add Dependent(s) (also complete #3, Part A) ☐ Enroll in Extended Coverage
Name: _____ Birth Date: _____/_____/_____ ☐ Change in Plan
Effective Date: _____ Social Security Number _____-_____-_____ ☐ Other (explain) _____

Other Coverage (Complete carefully. This information is subject to verification.)

Is this dependent covered by any other group hospital, medical-surgical, dental, or drug program? ☐ Yes ☐ No

If YES, complete the following:

Name of Policyholder _____

Subscriber's Identification No. _____ Employer Group No. _____ Effective Date _____
Month Year

☐ Drop Dependent(s)
Name: _____ Birth Date: _____/_____/_____ _____
Effective Date: _____ Social Security Number _____-_____-_____ _____

3. **Change in Type of Membership –** If you participate in your employer's Section 125 Cafeteria Plan, a Qualifying Mid-Year Event (QME) must usually occur to allow a membership change at any time other than within 31 days of employment or during the Open Enrollment Period. In most cases, the change in membership is effective the first of the month following submission of a completed application. Please list QME _____ and the date of occurrence: _____.

4. **Premiums –** The current monthly cost to me for the plan and type of membership I have selected is $_____, effective (date)* _____

The current and future cost (if any) of coverage may be deducted from my paycheck. If covered as a retiree, I will make my premium payments directly to my former employer. I understand that in order to terminate coverage, notice of cancellation must be made by completing Part C of the enrollment form and does not relieve me from payment for any month already begun.

Signature _____ Date _____

*Generally, the effective date for coverage is the first day of the month following your Group Benefits Administrator's receipt of this enrollment form. Should you need assistance contact your Group Benefits Administrator.

PART C. WAIVE OR CANCEL COVERAGE

Print Name _____
(First Name) *(M.I.)* *(Last Name)*

Social Security Number _____ - _____ - _____ Employer _____

Home Address _____

Mailing Address (if different) _____

IF RETIRING: Date of Retirement _____

WAIVE OR CANCEL COVERAGE:
I do not wish to enroll or to continue enrollment in The Local Choice Health Benefits Program for myself and my eligible family members. I understand that if I participate in my employer's Section 125 Cafeteria Plan, I may terminate coverage only during the Open Enrollment Period or with a Qualifying Mid-Year Event. I will not have another opportunity to enroll or add dependents unless I am actively employed by a participating local group.

Signature _____ Date _____ Effective Date _____

Generally, coverage will terminate on the last day of the month following your Group Benefits Administrator's receipt of this enrollment form. Should you need assistance contact your Group Benefits Administrator.

If you have elected to waive all rights to enrollment at this time, return this form to your Group Benefits Administrator.

GROUP APPROVAL/VERIFICATION

Group Name _____ Group Number _____ Effective Date _____

I certify that I have reviewed this enrollment form and that it is complete and accurate to the best of my knowledge.

Group Benefits Administrator's Signature _____ Date _____

Print Name and Title _____ Telephone (_____) _____
Area Code

IF NEW COVERAGE: Date employee's continuous, eligible employment began _____

If employee is a faculty member on a 9, 10, or 11-month contract, coverage begins _____ Duration of Contract _____
Months

If retirees are eligible for group coverage, the retiring employee has been told that the first premium will be in the amount of $ _____

Effective Date of ☐ Service Retirement _____ ☐ Disability Retirement_____

If Extended Coverage, Duration of Contract _____

Group Benefits Administrator to complete:

Effective Date:_____
Date of Employment:_____
Group Number: _____
Name of Group: _____